

§ 447.72

§ 447.72 Alternative premium and cost sharing exemptions and protections for individuals with family incomes above 100 percent but at or below 150 percent of the FPL.

(a) The State may not impose premiums under the State plan on individuals whose family income exceeds 100 percent, but does not exceed 150 percent, of the FPL.

(b) Cost sharing may be imposed under the State plan for individuals whose family income exceeds 100 percent, but does not exceed 150 percent, of the FPL if the cost sharing does not exceed 10 percent of the payment the agency makes for the item or service, with the following exceptions:

(1) Cost sharing for non-preferred drugs cannot exceed the nominal amount as defined in § 447.54.

(2) Cost sharing for non-emergency services furnished in the hospital emergency department cannot exceed twice the nominal amount as defined in § 447.54. A hospital must meet the requirements described at § 447.80(b)(2) before the cost sharing can be imposed.

(3) In the case of States that do not have fee-for-service payment rates, any copayment that the State imposes for services provided by an MCO to a Medicaid beneficiary, including a child covered under a Medicaid expansion program for whom enhanced match is claimed under title XXI of the Act, may not exceed \$3.40 per visit for Federal FY 2009. Thereafter, any copayment may not exceed this amount as updated each October 1 by the percentage increase in the medical care component of the CPI-U for the period of September to September ending in the preceding calendar year and then rounded to the next highest 5-cent increment.

(c) Aggregate cost sharing under sections 1916 and 1916A of the Act for all individuals in the family enrolled in Medicaid may not exceed the maximum permitted under § 447.78(a).

[73 FR 71851, Nov. 25, 2008, as amended at 75 FR 30264, May 28, 2010]

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§ 447.74 Alternative premium and cost sharing protections for individuals with family incomes above 150 percent of the FPL.

(a) States may impose premiums under the State plan consistent with the aggregate limits set forth in § 447.78(a) on individuals whose family income exceeds 150 percent of the FPL.

(b) Cost sharing may be imposed under the State plan on individuals whose family income exceeds 150 percent of the FPL if the cost sharing does not exceed 20 percent of the payment the agency makes for the item or service (including a non-preferred drug but not including non-emergency services furnished in a hospital emergency department), with the following exception: In the case of States that do not have fee-for-service payment rates, any copayment that the State imposes for services provided by an MCO to a Medicaid beneficiary, including a child covered under a Medicaid expansion program for whom enhanced match is claimed under title XXI of the Act, may not exceed \$3.40 per visit for Federal FY 2009. Thereafter, any copayment may not exceed this amount as updated each October 1 by the percentage increase in the medical care component of the CPI-U for the period of September to September ending in the preceding calendar year and then rounded to the next highest 5-cent increment.

(c) Aggregate premiums and cost sharing under sections 1916 and 1916A of the Act for all individuals in the family enrolled in Medicaid may not exceed the maximum permitted under § 447.78(a).

[75 FR 30264, May 28, 2010, as amended at 75 FR 38749, July 1, 2010]

§ 447.76 Public schedule.

(a) The State must make available to the groups in paragraph (b) of this section a public schedule that contains the following information:

(1) Current premiums, enrollment fees, or similar fees.

(2) Current cost sharing charges.

(3) The aggregate limit on premiums and cost sharing or just cost sharing.

(4) Mechanisms for making payments for required premiums and charges.

(5) The consequences for an applicant or beneficiary who does not pay a premium or charge.

(6) A list of hospitals charging alternative cost sharing for non-emergency use of the emergency department.

(7) Either a list of preferred drugs or a method to obtain such a list upon request.

(b) The State must make the public schedule available to the following:

(1) Beneficiaries, at the time of their enrollment and reenrollment after a redetermination of eligibility, and when premiums, cost sharing charges, or aggregate limits are revised.

(2) Applicants, at the time of application.

(3) All participating providers.

(4) The general public.

(c) Prior to submitting to the Centers for Medicare & Medicaid Services for approval a State plan amendment (SPA) to establish alternative premiums or cost sharing under section 1916A of the Act or an amendment to modify substantially an existing plan for alternative premiums or cost sharing, the State must provide the public with advance notice of the amendment and reasonable opportunity to comment with respect to such amendment in a form and manner provided under applicable State law, and must submit documentation with the SPA to demonstrate that this requirement was met.

[73 FR 71851, Nov. 25, 2008, as amended at 75 FR 30264, May 28, 2010]

§ 447.78 Aggregate limits on alternative premiums and cost sharing.

(a) The total aggregate amount of premiums and cost sharing imposed under sections 1916 and 1916A of the Act for all individuals in a family enrolled in Medicaid with family income above 100 percent of the FPL may not exceed 5 percent of the family's income for the monthly or quarterly period, as specified by the State in the State plan.

(b) The total aggregate amount of cost sharing imposed under sections 1916 and 1916A of the Act for all individuals in a family enrolled in Medicaid with family income at or below 100 percent of the FPL may not exceed 5 percent of the family's income for the

monthly or quarterly period, as specified by the State in the State plan.

(c) Family income shall be determined in a manner, for such period, and at such periodicity as specified by the State in the State plan, including the use of such disregards as the State may provide and the process for individuals to request a reassessment of the family's aggregate limit if the family's income is reduced or if eligibility is being terminated due to nonpayment of a premium.

(1) States may use gross income or any other methodology.

(2) States may use a different methodology for determining the family's income to which the 5 percent aggregate limit is applied than is used for determining income eligibility.

[75 FR 30264, May 28, 2010]

§ 447.80 Enforceability of alternative premiums and cost sharing.

(a) With respect to alternative premiums, a State may do the following:

(1) Require a group or groups of individuals to prepay.

(2) Terminate an individual from medical assistance on the basis of failure to pay for 60 days or more.

(3) Waive payment of a premium in any case where the State determines that requiring the payment would create an undue hardship for the individual.

(b) With respect to alternative cost sharing, a State may amend its Medicaid State plan to permit a provider, including a pharmacy or hospital, to require an individual, as a condition for receiving the item or service, to pay the cost sharing charge, except as specified in paragraphs (b)(1) through (3) of this section.

(1) A provider, including a pharmacy and a hospital, may not require an individual whose family income is at or below 100 percent of the FPL to pay the cost sharing charge as a condition of receiving the service.

(2) A hospital that has determined after an appropriate medical screening pursuant to § 489.24 of this chapter, that an individual does not need emergency services as defined at section 1932(b)(2) of the Act and § 438.114(a), before providing treatment and imposing alternative cost sharing on an individual in